HCF/BES 114D
1/05

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

(For the Division of Health Care Financing and the Department of Workforce Services to Disclose Information)

_____ _____ _____/_____/_____

Client Name **Social Security #** **Date of Birth**

I _____ hereby authorize the
(Client or Personal Representative)

Utah Department of Health, through its Division of Health Care Financing or the Department of Workforce Services to disclose specific health information from the records of the above named client to:

_____.
(Person or Organization Receiving the Information)

The specific health information authorized for disclosure is: _____

_____.

The purpose of the disclosure is:

_____.

I understand that this authorization will expire on the following date, event, or condition: _____

_____.

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose. I also understand that I may revoke this authorization at any time, by sending written notification to Privacy Officer indicated in the Notice of Privacy Practices already provided to the client (a duplicate Notice of Privacy Practices can be provided upon request when filling out this authorization). I understand that a revocation is not effective to the extent that the Division of Health Care Financing or the Department of Workforce Services has relied on the disclosed health information.

I understand that I may refuse to sign this authorization. I also understand that the Division of Health Care Financing or the Department of Workforce Services cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign this authorization.

I understand that, once information is disclosed pursuant to this authorization, it is possible that it will no longer be protected by medical privacy laws and could be redisclosed by the person or agency that receives it.

By signing, I acknowledge I have been provided a copy of this signed authorization.

_____/_____
Signature of Client or Authorized Representative Date

If signed by an Authorized Representative, a description of authority to serve: _____